CORE PROVIDER AGREEMENT

DIVISION OF MEDICAL ASSISTANCE

The Department of Social and Health Services (the department) provides a medical care program administered by the Division of Medical Assistance.

The medical care program is offered through the use of certified providers of medical services. To be certified, eligible providers shall apply for a provider number and sign this agreement and shall meet all the applicable state and/or federal licensure requirements to assure the department of his/her qualifications to perform said services. In the case of group practice, each individual practitioner shall meet the licensure requirements.

A provider is not considered to be participating until a provider number is issued, and the provider bills and accepts payment from the department.

The Medicaid program is authorized by Social Security Act, Title XIX of Public Law 89-97, 42 CFR Chapter IV, RCW Chapter 74.09, and WAC Chapters 388-80 through 388-95. In case of conflict or inconsistency, the following order of precedence applies.

a) 42 U.S.C., 1302, 1395, et seq.
b) Code of Federal Regulations (CFR)
c) Revised Code of Washington (RCW)
d) Washington Administrative Code (WAC)
e) Department numbered memoranda
f) Schedule of Maximum Allowances/Fee Schedules
g) Drug Formulary and Therapeutic Index
h) Billing instructions

A provider must bill the department for services rendered to eligible recipients, as identified by a DSHS medical coupon. Reimbursement for covered services will be made according to the Schedule of Maximum Allowances, the drug formulary and other applicable payment levels or schedules. This must be accepted as sole and complete remuneration for services covered under the program. The provider may bill the recipient at the usual and customary charge for deductibles or services not covered by the program.

In the event that a provider receives payments from the department in error or in excess of the amount properly due under the applicable rules and procedures, the provider will promptly refund to the department any excess money so received. In the event that additional funds are due the provider, adjustment will be made upon discovery by the department or upon receipt of a written request.

A provider shall bill usual and customary charges or according to instructions issued by the department.

Documentation and records as specified by WAC 388-81-015 and 388-87-007 must be maintained to support the services and levels of service billed. These records and supportive material must be available to the department and the Department of Health and Human Services upon request. Audits may be conducted to determine compliance with the rules and regulations of the program. In accordance with RCW 74.09.290(1), only those patient records, or portions thereof, for which services were reimbursed by the department may be examined.

Based upon findings of an audit, investigation or other proceedings, the department may order repayment of excess benefits or payments plus interest on the excess benefits and assess civil penalties. Civil penalties may be assessed in the amount not to exceed three times the amount of excess benefits or payments as defined in RCW 74.09.210 through 280 for fraudulent or abusive practices.

A provider will be held to all the terms of this agreement even though a third party may be involved in billing claims to the department. It is a breach of this agreement to discount recipient accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected. If a provider elects to bill the department by a tape-to-tape claims processing method or through a third party biller, a copy of the power-of-attorney to the billing agent must be submitted binding the biller to the applicable terms of this agreement. Providers electing to use tape-to-tape submission must sign an additional agreement.

The provider shall complete Appendix A and notify the department within thirty (30) days of any status changes to information contained therein. A change in ownership cancels this agreement and a new agreement and provider number must be requested.

The department and the provider agree to hold each other harmless from all legal action based on the negligent actions or omissions of either party under the terms of this agreement.

A provider may terminate this agreement at any time by giving written notice. The department may terminate this agreement with thirty (30) days written notice stating the reasons for the proposed termination and the right for review. In the event that funding from the state, federal, or other sources is withdrawn, reduced,

SIGNATURE REQUIRED ON REVERSE SIDE

or limited in any way, the department may terminate this agreement. The thirty (30) day notice shall not be required if a provider is convicted of a criminal offense related to participation in the Medicare/Medicaid program, if his/her license is suspended or revoked, or if the quality of care provided is such that the health and safety of recipients is endangered.

Whenever the department fails to make payment within 45 days of receipt of a properly completed invoice for medical care, interest will be paid at the rate of one percent per month of the allowed amount, but at least one dollar per month.

Non-Discrimination Clause

As provided in WAC 388-87-007, a provider to the departmental Medical Assistance program shall agree to provide necessary medical services, items, and/or products consistent with his/her profession and that all services rendered and goods or products furnished have been provided without discrimination on the grounds of age, sex, marital status, race, creed, color, religion, or national origin, or the presence of any sensory, mental or physical handicap. Providers maintain the right to accept patients into their practice consistent with professional standards.

The provider, _____
(Print or Type)

a _____
(Profession)

agrees to abide by the terms of this agreement and by all applicable federal and state statutes, rules, and procedures.

_____
DATE

SIGNATURE OF PROVIDER OR OWNER/MANAGER

CONTRACTING OFFICER
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

☐ TAX ID CHANGE ☐ NEW ☐ UPDATE

PLEASE SEND COPY OF:

- ☐ BUSINESS LICENSE
- ☒ PROFESSIONAL LICENSE
- ☐ GRADUATION OF PSYCHIATRY RESIDENT PROGRAM CERTIFICATE
- ☐ STATE ISSUED HOSPITAL LICENSE
- ☐ RN AND ARNP LICENSE
- ☐ ASHA CERTIFICATE
- ☐ MEDICARE CERTIFICATION
- ☐ HCFA 1557 FORM
- ☐ HOME HEALTH AGENCY LICENSE
- ☐ HEARING AID FITTING AND DISPENSING LICENSE
- ☐ RADIOLOGY CERTIFICATION/REGISTRATION
- ☐ OTHER:

PROVIDER ENROLLMENT
PO BOX 45562
OLYMPIA WA 98504-5562

APPENDIX A

CURRENT PROVIDER NUMBER

PROVIDERS MUST NOTIFY THE DEPARTMENT WITHIN THIRTY (30) DAYS OF ANY STATUS CHANGES TO INFORMATION IN THIS APPENDIX. A CHANGE IN OWNERSHIP CANCELS THIS AGREEMENT AND A NEW AGREEMENT AND PROVIDER NUMBER MUST BE REQUESTED.

PHYSICIANS, OPTOMETRISTS, OR DENTISTS PRACTICING UNDER AN INDIVIDUAL PROVIDER NUMBER: THE AGREEMENT MUST BE SIGNED BY THE PHYSICIAN. SECTIONS I AND II OF APPENDIX A MUST BE COMPLETED.

PHYSICIANS, OPTOMETRISTS, OR DENTISTS PRACTICING UNDER A GROUP PROVIDER NUMBER: THE AGREEMENT MUST BE SIGNED BY THE CLINIC MANAGER. SECTION I MUST BE COMPLETED FOR THE CLINIC FACILITY; SECTION II MUST BE COMPLETED FOR EACH PHYSICIAN PRACTICING UNDER THE GROUP NUMBER. ADDITIONAL SPACES FOR SECTION II ARE PRINTED ON THE BACK OF APPENDIX A.

PHARMACIES: THIS AGREEMENT MUST BE SIGNED BY THE OWNER OR MANAGER OF THE PHARMACY. SECTION III MUST BE COMPLETED FOR EACH PHARMACIST PRACTICING UNDER THE PROVIDER NUMBER.

HOSPITALS: THE AGREEMENT IS TO BE SIGNED BY THE HOSPITAL ADMINISTRATOR. SECTION I IS TO BE COMPLETED FOR THE FACILITY.

PHYSICAL THERAPISTS, PSYCHOLOGISTS, ETC.: THE AGREEMENT IS TO BE SIGNED BY THE PERSON WHO PERFORMS THE SERVICES. IN THE CASE OF A GROUP PRACTICE, THE CLINIC MANAGER OR OWNER MUST SIGN. SECTION III IS TO BE COMPLETED WITH APPROPRIATE INFORMATION FOR EACH PROFESSIONAL.

SUPPLY, AMBULANCE, OPTICAL, OR TRANSPORTATION COMPANIES: THE AGREEMENT MUST BE SIGNED BY THE OWNER OR MANAGER OF THE COMPANY. SECTION I IS TO BE COMPLETED FOR THE COMPANY.

I. TO BE COMPLETED BY ALL PROVIDERS.

PLEASE SEND COPY OF CURRENT LICENSE

NAME OF OWNER(S)		
BUSINESS NAME (as you wish your account set up by the department)	EFFECTIVE DATE	BUSINESS PHONE

PHYSICAL BUSINESS ADDRESS	MAILING ADDRESS

TYPE OF PRACTICE	SPECIALTY	CITY LICENSE NO.	IRS NO:
PROFESSIONAL LICENSE NO.	MEDICARE PROVIDER NO.	MEDICARE CERTIFICATION NO. (If applicable)	SOCIAL SECURITY NO.
SIGNATURE OF AUTHORIZED AGENT		SIGNATURE OF AUTHORIZED AGENT	

II. TO BE COMPLETED BY EACH PHYSICIAN, OPTOMETRIST, OR DENTIST PRACTICING UNDER THE ABOVE PROVIDER NAME/NUMBER (additional spaces on the back).

PLEASE SEND COPY OF CURRENT LICENSE

NAME		PROFESSIONAL LICENSE NO.	MEDICARE PROVIDER NO.
N/A		N/A	N/A
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY	MEDICAID PROVIDER NO.
N/A	N/A	N/A	N/A
SOCIAL SECURITY NO.	DEA (NARCOTIC) NO.	SIGNATURE	
N/A	N/A	N/A	

III. TO BE COMPLETED FOR NON-PHYSICIAN PRACTITIONERS (Pharmacists, Psychologists, Physical Therapists, Audiologists, Speech Pathologists, Prosthetists/Orthotists, Midwives, Certified Registered Nurses, etc.) PRACTICING UNDER THE ABOVE NAME/NUMBER:

PLEASE SEND COPY OF CURRENT LICENSE

NAME(s)	TYPE OF SERVICE	LICENSE NUMBER